PATIENTS' PERCEPTION OF WEIGHT-RELATED STIGMA IN A ROMANIAN SAMPLE

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- The slim figure promoted by media has been accepted by the modern urban civilization, and overweight people began to be considered unattractive, less competent and sociable, sloppy and having less healthy eating habits.
- People develop negative stereotypes regarding obese individuals and the process of stigmatizations links those individuals with these negative stereotypes.
- Obesity is still an undesired condition within society, associated with negative attributes. Overweight persons are often stigmatized and are regarded as being personally responsible for their obesity (Hilbert, A., Rief, W., & Braehler, E., 2008).

- Stigma is a multidimensional concept and comprises the degree in which obese individuals are subject to discrimination, prejudice, and stereotypes.
- Enacted stigma refers to directly discriminatory behaviors by others toward those in the stigmatized group in areas such as employment, interpersonal relationships, housing, and reduced access to services (De Brún, A., McCarthy, M., McKenzie, K., & McGloin, A, 2014).

- Perceived stigma reflects the subjective awareness of stigma. It is identified as an emotional response to enacted stigma and may lead to feelings of isolation or exclusion (Puhl, R. M., & Heuer, C. A., 2009; Hübner, C., Schmidt, R., Selle, J., Köhler, H., Müller, A., de Zwaan, M., & Hilbert, A., 2016).
- After identifying stigma directed at obese people, an overweight individual will frequently develop stigmatizing thoughts about himself. In other words, identification with a stigmatized group may lead to internalized or self-stigma (Link, B.G. & Phelan, J.C., 2001).

- Weight-related stigma was assessed using a translated version of the Weight Self-Stigma Questionnaire (WSSQ). The test consists of a self-administered, 12-item Likert scale (where “1” is “completely disagree” and “5” is “completely agree”).
- The score is calculated by adding the scores of each item, and the scale contains two subscales, one for “self-devaluation,” consisting of the added scores for the first six items, and one for “fear of enacted stigma,” consisting of the added scores of the last six items.
- The questionnaire was translated from the original by a multi-lingual team of university staff, familiar with both languages, and with bariatric pathology.

weight-related self-devaluation (subscale1,items 1–6)

fear of enacted stigma (subscale 2, items 7–12)

- 1. I'll always go back to being overweight
- 2. I caused my weight problems
- 3. I feel guilty because of my weight problems
- 4. I became overweight because I'm a weak person
- 5. I would never have any problems with weight if I were stronger
- 6. I don't have enough self-control to maintain a healthy weight

- 7. I feel insecure about others' opinions of me
- 8. People discriminate against me because I've had weight problems
- 9.It'sdifficultforpeoplewhohaven'thadweightproblemstorelatetome
- 10. Others will think I lack self-control because of my weight problems
- 11. People think that I am to blame for my weight problems
- 12. Others are ashamed to be around me because of my weight

Statistical analysis

- Correlation between age, age of onset, duration of illness, BMI and WSSQ total- and sub-scores were analyzed using the Pearson correlation method, and the statistics software SPSS version 23.
- In order to detect any statistically significant differences between groups, three one-way ANOVA analyses have been conducted, evaluating the differences in total stigma and subscales between groups.

N=99		Frequency	Percent (%)
Gender	Male	28	28.3
	Female	71	71.7
Civil Status	Single	4	13
	Married	19	59
	Divorced	1	3
	Widowed	8	25
Educational Status	Elementary	2	6
	Middle School	26	81
	High School or Higher	4	13
Treatment	None	89	89.9
	Fibrates	2	2.0
	Statines	7	7.1
	Mixed	1	1
Obesity Type	Harmonious	33	33
	Android	15	15.2
	Visceral	24	24.2
	Gynoid	22	22.2
Desire for surgery	No	58	58.6
	Yes	41	41.4

Results

- As expected, BMI presents significant correlations with total WSSQ score ($p<.05$), and with the “fear of enacted stigma” sub-score ($p<.01$).
- Age presents a moderate and significant correlation with BMI ($p<.01$), as does age of onset ($p<.01$).
- **Stigma and obesity types**
- Splitting the group into four sub-samples based on obesity type revealed no significant differences in stigma between any of the types.

	No desire for surgery (N=58)	Desire for surgery (N=41)
BMI	38.18±5.46	44.69±6.91
WSSQ Self Stigma	21.29 ± 5.37	21.51±4.77
WSSQ Enacted Stigma	13.98 ± 6.80	17.12±6.17
WSSQ Total	35.27 ± 10.32	38.63±9.30

Discussions

- To our knowledge, our study represents the first study evaluating the weight self-stigma and its association with body mass index, duration of illness, obesity type, and surgery-seeking status among obese Romanian patients.
- Results indicated that age at study inclusion, and age of onset were highly correlated ($p<.01$), yet the duration of obesity presents no significant relationship with BMI

- Of interest is also the lack of any significant relationships between the “self-stigma” sub-score and age parameters, or BMI.
- In our study experiencing greater fear of enacted stigma (fear of being discriminated against) was significantly associated with BMI.
- Previous findings produced heterogeneous results with regard to the association of weight stigma and BMI: while weight stigma was positively correlated with BMI in several studies (Lillis, J., Luoma, JB., Levin, ME., Hayes, SC., 2009; Pearl, R. L., White, M. A., & Grilo, C. M., 2014). Other studies failed to provide an association between internalized weight stigma and BMI (Durso, L.E.& Latner J.D.,2008; Hain, B., Langer, L., Hünnemeyer, K., Rudofsky, G., Zech, U., Wild, B., 2015).
- More specifically, our study failed to show a significant difference in stigma between any of the obesity subtypes (harmonious, android, gynoid and visceral obesity).
- Regarding the surgery seeking status, a significant difference between groups was found for the fear of enacted stigma sub-score, individuals with desire for surgery presenting higher scores of fear of enacted stigma sub-scores.

- More research is clearly needed to examine the factors that are necessary for stigma reduction strategies, considering the cultural and social norms. Nevertheless, given the limited research in this area, more work is needed to examine how the internalization of stigma influences the health-related quality of life, maladaptive eating behaviors, and exercise avoidance in Romanian patients.
- Our study highlight the need to provide increased support as well as psychotherapy designed to help obese individuals to cope with their personal history of encountering weight-related stigma in order to promote improved health-related quality of life.

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